

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-018657

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1359

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4000

2 217

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEMAP</u>		c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MARIE MANOR NURSING HOME</u>		d. STREET ADDRESS (If outside, give location): <u>3965 CLEVELAND</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>VICTORIA</u> Last <u>SHAW</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 25, 1889-73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11a. FATHER'S NAME <u>HENRY BROOKINS</u>		11b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
11c. NAME OF HUSBAND OR WIFE <u>HERBERT SHAW (DEC)</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		14. SOCIAL SECURITY NO. <u>LOUISE MILLER 1955 Wyoming</u>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension Cardiovascular Disease</u> DUE TO (c) <u>4+3x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4y</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>11:45</u> a.m. p.m. Month, Day, Year <u>1955</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>ST LOUIS MO</u> COUNTY STATE	
21. I attended the deceased from <u>1955</u> to <u>1963</u> and last saw her alive on <u>4-7-63</u> . Death occurred at <u>11:45 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John J. Doherty M.D.</u>		22b. ADDRESS <u>5203 Clayton St St Louis Mo</u>	
22c. DATE SIGNED <u>11-23-63</u>		22d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	
23a. BURIAL, CREMATION, REMOVAL, etc. <u>BURIAL</u>	23b. DATE <u>APR. 26, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Lutz 2906 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>4-24-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4772

P. O. Address 2906 Maas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

Mr. J. A. Humphrey
5203 Chicago
Ill. 60632
2-6-36